Global Mental Health 5

Barriers to improvement of mental health services in low-income and middle-income countries

Benedetto Saraceno, Mark van Ommeren, Rajaie Batniji, Alex Cohen, Oye Gureje, John Mahoney, Devi Sridhar, Chris Underhill

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Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland (B Saraceno MD, M van Ommeren PhD); **Department of Politics and International Relations, University of Oxford, Oxford, UK** (R Batniji MA); **Department of Social Medicine, Harvard Medical School, Boston, USA** (A Cohen PhD); **Department of Psychiatry, University of Ibadan, Ibadan, Nigeria** (Oye Gureje DSc); **World Health Organization Sri Lanka, Colombo, Sri Lanka** (J Mahoney); **Department of Politics and International Relations, University of Oxford, UK** (D Sridhar DPhil); **and BasicNeeds, Leamington Spa, UK** (C Underhill MSc)

Correspondence to: Dr Benedetto Saraceno, Department of Mental Health and Substance Abuse, World Health Organization, CH-1211, Geneva, Switzerland, **saracenob@who.int**

Despite the publication of high-profile reports and promising activities in several countries, progress in mental health service development has been slow in most low-income and middle-income countries. We reviewed barriers to mental health service development through a qualitative survey of international mental health experts and leaders. Barriers include the prevailing public-health priority agenda and its effect on funding; the complexity of and resistance to decentralisation of mental health services; challenges to implementation of mental health care in primary-care settings; the low numbers and few types of workers who are trained and supervised in mental health care; and the frequent scarcity of public-health perspectives in mental health leadership. Many of the barriers to progress in improvement of mental health services can be overcome by generation of political will for the organisation of accessible and humane mental health care. Advocates for people with mental disorders will need to clarify and collaborate on their messages. Resistance to decentralisation of resources must be overcome, especially in many mental health professionals and hospital workers. Mental health investments in primary care are important but are unlikely to be sustained unless they are preceded or accompanied by the development of community mental health services, to allow for training, supervision, and continuous support for primary care workers. Mobilisation and recognition of non-formal resources in the community must be stepped up. Community members without formal professional training and people who have mental disorders and their family members, need to partake in advocacy and service delivery. Population-wide progress in access to humane mental health care will depend on substantially more attention to politics, leadership, planning, advocacy, and participation.

Introduction

International public-health concerns for mental health have been accelerated by the World Development Report 1993[1] and the subsequent Global Burden of Disease report,[2] which compared health conditions based on combined disability and mortality statistics. Although they did not make any explicit policy recommendations on mental health services, these reports showed, to the surprise and disbelief of many in the international public-health arena, the huge burden of disease imposed by mental disorders, not only in rich countries but also in low-income and middle-income countries.

Data on the global burden of disease prompted three high-profile international reports (table 1),[3–5] and many important regional and national reports.[6–12] Notably, one regional report[12] was signed by all European ministers of health, including those from 27 low-income and middle-income countries in Eastern Europe. They committed to implementation of a detailed plan for service development, prevention of mental problems, and promotion of wellbeing.[12]

The global, high-level reports were largely concerned with the wellbeing of people affected by mental disorders: they called on decisionmakers to do everything in their

	WMH (1995)	IOM (2001)	WHO (2001)
Extend and improve care	Upgrade the quality of mental health services Improve mental health services for children and adolescents Develop effective treatment and demand-reduction programmes for substance abuse	Use cost-effective interventions for those who will benefit and follow best practice guidelines; provide essential medications Extend and strengthen existing systems of primary care to deliver health services for brain disorders	Give care in the community Provide treatment in primary care Make psychotropic drugs available Link with other sectors
Strengthen the workforce to provide care	Upgrade amount and quality of training for all health workers	Through secondary and tertiary centres, train and oversee primary-care staff, provide referral capacity, and provide ongoing supervision and support for primary-care systems Create national centres for training (and research) on brain disorders, linked with institutions in high-income countries	Develop human resources
Strengthen other mental health system components that enable provision of care		Increase public and professional awareness; reduce stigma and discrimination	Establish national policies, programmes, and legislation Involve communities, families, and consumers Educate the public

WMH=World Mental Health.[3] IOM =Institution of Medicine.[4] WHO= World Health Report.[5] This is a summary of the recommendations in the books, rather than of the available summary documents. In addition to these 17 recommendations, the three reports together contain nine further recommendations on social determinants, prevention of mental disorders, and research.

Table 1: **Mental health recommendations from three high-level reports**

power to organise care for those with mental disorders. One included extensive analysis of social factors in mental disorders, and mental wellbeing;[3] another emphasised epidemiology and interventions for specific brain disorders;[4] and the third focused especially on mental health policies and services.[5] Despite these differences, the mental health service recommendations offered in these three reports are largely consistent (table 1). Their recommendations on services are of two kinds: direct recommendations to increase the availability of care, and recommendations on mental health system components to enable provision of more or better care, such as development of human resources or changes to mental health policy.

This *Lancet* Series has reviewed epidemiological evidence,[13] availability of mental health resources,[14] evidence for interventions in mental health,[15] and the status of mental health system development in countries, including the extent of national-level progress in mental health service development.[16] The Series reviewed the availability of mental health resources in 152 low-income and middle-income countries by analysis of data collected in 2001 and 2004.[17,18] The review[16] suggests that improvements in the availability of mental health resources between 2001 (when two of the high-profile reports[4,5] were published) and 2004 were only slight. National-level successes (for example, case studies on Brazil,[16] Chile,[15] and Sri Lanka in panel 1) have occurred, though in most countries mental health service development continues to be fragmented and slow.[16]

Despite the wide dissemination of high-level reports[3–5] and evidence for the range of mental health interventions reviewed earlier in this Series,[15] progress in scaling-up has not been as hoped. What hinders progress? Is it simply insufficient donor interest? If so, why? Or do other political or technical barriers exist? We aim to address these complex questions here to inform the *Lancet*'s call for action.[26] Many of the barriers and lessons identified in this review will be common sense to experienced public-health experts, but the aim is to make them explicit, so that they become powerful tools for public mental health action.

Key barriers to service development

To understand the challenges to progress in the improvement of the quality and availability of mental health care in most low-income and middle-income countries, we surveyed a range of international experts and leaders. Our methods and results are reported in detail elsewhere,[27] and panel 2 summarises the methods. We discuss the prevailing public-health priority agenda and its effect on funding; the complexity of and resistance to decentralisation of mental health services; challenges in implementation of mental health care in primary-care settings; the limited numbers and types of workers who are trained and supervised in mental health care; and the general scarcity

Panel 1: Sri Lanka: political will for mental health after a major disaster

Disasters can have devastating social and mental health effects.[19] Professional understanding of these effects, paired with post-emergency mental health interest by the public (including media and politicians), can provide enormous opportunities for mental health system development. Before the 2004 tsunami, Sri Lanka's formal mental health resources were mainly invested in mental hospitals in and around the capital, Colombo. Despite many efforts and important initiatives,[20–22] mental health advocates (who were often at odds with one another) struggled to put mental health on the development agenda.

The political interest in and priorities related to mental health dramatically changed after the tsunami, which killed 35 322 Sri Lankans and displaced about 1 million people.[23] A presidential committee was set up immediately, to provide support for mental health relief. During the following months, aid agencies offered various short-term mental health and social supports to Sri Lankans. Immediately after the emergency, the Ministry of Health, with sustained support from WHO, took steps to maintain the interest in mental health by initiation of a policy-development process. 10 months after the disaster, after consultation with a broad range of health-sector stakeholders, the Sri Lankan government approved a new, consensus-based National Mental Health Policy.[24] The new policy guides efforts to strengthen the governance, management, and administration of mental health services and to reconfigure the organisation of mental health services so that care will be locally available in all districts. The policy emphasises human-resource development by outlining the appointment of different types of staff to all districts. The national policy's vision includes acute inpatient care by a multidisciplinary team in each district. With the acute unit as a basis, the vision encompasses both fixed and mobile outpatient clinics throughout each district, and training and supervision of workers in mental health care, as was already happening in a few districts before the tsunami.[7] By the end of 2007, 18 out of 27 districts (67%) will have functioning acute inpatient units within general hospital settings, compared with 10 out of 27 (37%) before the tsunami (figure). The political will for mental health in Sri Lanka continues with the Ministry of Health's active interest in new mental health legislation.

Figure: **Construction of a mental health unit in Kalmunai, Sri Lanka**
Staff organise acute inpatient care and outreach clinics across Kalmunai, which is the district that has been most severely affected by the tsunami.

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Many challenges remain. First, innovative measures will be needed to employ qualified professionals in districts far away from Colombo. Such measures are being identified and implemented. The Ministry of Health is working with the national College of Psychiatrists to develop a new cadre of diploma holders, who will have 1 year of postgraduate training in psychiatry. The ministry will appoint these trained diploma holders to work in all districts to coordinate and provide mental health care. The idea is an extension of another innovative Sri Lankan invention, medical officers for mental health, who have 3 months of training in psychiatry.[20] These personnel have been key in the provision of psychiatric care in many districts in recent years. Their numbers will increase from the present 57 to 257. A second major challenge is Sri Lanka's colonial legacy—ie, about four of every five psychiatry beds in the country are in large mental hospitals near Colombo. A WHO survey that used the Community Placement Questionnaire[25] showed that 978 (58%) of 1678 long-stay patients in mental hospitals could immediately leave the hospital and lead normal lives outside these facilities if they had places to stay and sufficient support in the community (Mahoney J; unpublished data, 2006). Negotiations with and recruitment of donors and local non-governmental organisations to provide such support is underway. In 2006, a nurse from every ward in one of the large hospitals in Sri Lanka was trained in rehabilitation in Bangalore, India, which substantially improved the quality of care. Other large psychiatric hospitals will soon be included in similar programmes. The active nurturing of opportunities in the aftermath of a major tragedy has resulted in substantial changes in the Sri Lankan mental health system.

Panel 2: Search strategy on opinion of experts and leaders

We surveyed a select group of international experts and leaders—all with experience and knowledge of low-income and middle-income countries. Our qualitative survey included seven open-ended questions about barriers and facilitating factors for mental health funding and development of mental health services in low-income and middle-income countries. Of 60 people we asked to participate, 50 (83·3%) responded. Seven additional individuals spontaneously submitted responses to the survey after it was shared with them by their invited colleagues. Our analyses cover these 57 responses. Accounting for multiple affiliations, we gathered the opinions of 12 current or previous senior national-government decisionmakers on mental health, eight civil-society leaders without training in mental health, 13 civil-society specialists or leaders in mental health services, three general public-health leaders, 20 associate or full professors, and 20 current or previous international advisers or consultants on mental health services. These international advisers or consultants on mental health services included one current and four previous WHO Regional Mental Health Advisers. At the time of survey, respondents were based in 30 countries, including 18 low-income and middle-income countries. In total, we recorded 90 848 words of responses.

Two data analysts (RB and DS), who were unfamiliar with the international discourse on mental health services, analysed the text thematically. To reduce the risk of bias, these two analysts were unaware of the identities and affiliations of respondents during this initial stage. They read the texts separately, then conferred and agreed on themes that they had each independently identified. They then reread all responses to categorise text that related to the agreed themes. Since this analysis focused on broad themes, it only encompasses a subset of all issues raised by respondents. Further in-depth analyses would probably identify further barriers and facilitating factors.

Limitations of our analyses include the fact that the views expressed are those of senior experts and not of grass-roots workers, consumer groups, or other stakeholders. Also, the analysis does not cover the broad historical, geopolitical, and sociodemographic contexts in different countries. Finally, the review is focused on development of mental health services for people with mental disorders, and thus does not cover barriers to prevention of disorders, or to protection and promotion of psychosocial wellbeing in the general population.

of public-health perspectives in mental health leadership. The findings are summarised in table 2.

The public-health priority agenda and its implications for funding

In response to a question about available funds for mental health services, respondents said that mental health had a low position on public-health agendas at national and international levels. They were concerned that mental health was named neither as a Millennium Development Goal (MDG) nor as an MDG-related target, despite established links between mental disorders and MDGs.[13]

Absence from the international public-health agenda can block progress even when investment in mental health has been agreed at the national level, as was the case in Rwanda:

> "Rwanda, recognising the impact of the 1994 genocide as well as the rising rates of HIV infection, included mental health in the 2002 Poverty Reduction Strategy Paper document. However, when it came time to determine what will be financed within the Poverty Reduction Strategy Credit, mental health was not included, since it is not explicitly mentioned as an MDG. The result is that the Rwandan Ministry of Health cannot finance mental health services out of the World Bank loan/credit funds, even if mental health is an expressed need, an observed need, and a mental health strategy exists."
>
> *F Baingana (formerly of the World Bank)*

A raised profile on national and international agendas is not only essential for augmentation of funds but also for generation of the political support needed for the difficult decisions that are often part of mental health services reform.

Respondents identified a range of factors to explain the inadequacy of funding for mental health, which we take as a proxy indicator for a low position on the agenda. First, advocates for mental health might have different perspectives, which leads to contradictory messages. One observer, who was from outside the mental health profession, P Salama (Health Section, UNICEF), noted that "the field has suffered from a real and perceived lack of consensus among leading experts. This turns donors and policymakers off." Because there are many types of mental health problems, advocates for mental health often lobby against one another to draw attention to different mental health problems (eg, severe mental disorders *vs* trauma-induced disorders *vs* lack of wellbeing), each of which might need different public mental health solutions. Yet, even when advocates agree on problem definition (eg, a focus on severe mental disorders), they too often offer competing views on the type of actions needed to address the problem, despite the evidence base that exists for specific interventions.[15] Respondents commented that fragmentation in advocacy by different stakeholders—including governmental and non-governmental organisation service-providers,

consumers, family members, professional associations, leaders in mental health from non-governmental organisations, academics, and staff of international agencies—has prevented progress in many countries. R Jenkins (Institute of Psychiatry, London, UK) notes that senior psychiatrists in low-income and middle-income countries often prioritise increased expenditure on specialist services, which can be perceived by donors as "special pleading, not a priority, and not serving population needs."

Second, respondents argued that advocacy and other communications by mental health practitioners might not be clearly understood by others. The concepts in mental health discourse are complex, diverse, often theoretical, and not clearly communicated to decisionmakers. D do Nascimento, former Director of mental health of Brazil, noted that "Mental health professionals have a hermetic discourse, difficult to understand by their colleagues in other sectors of health care. Some effort is needed to simplify this discourse." Many advocacy efforts could have failed because they were not sufficiently clear.

Third, respondents pointed to the perception that mental health indicators were not sufficiently strong. Despite the measurability of mental disorders and the various components of mental health systems,[28,29] respondents noted that mental health does not use indicators that are as tangible and convincing as, for example, mortality or vaccination coverage. This *Lancet* Series recommends that a set of simple, consensus-based indicators be monitored to track the progress of countries towards attainment of specific targets.[26]

Fourth, respondents argued that advocacy for mental health has been weak because people with mental health problems and their families are too often invisible, voiceless, or at the margins of society. People with mental disorders and their families in low-income and middle-income countries are only rarely mobilised to form powerful constituencies, and to press for the availability of effective and humane mental health care. However, there are notable exceptions, such as in Zambia.

> "The formation of a consumer movement in 2000 and involvement of family members played a very important part in mental health reforms. With clients and family members as stakeholders in mental health, there was demand that medical treatment should be a basic right for persons with mental health problems. Furthermore, in providing treatment and in protecting patients, we demanded that basic human rights must be protected. These demands led to some reforms in mental health as the government strived to respond to our demands."
>
> *C S Katontoka (Mental Health Users Network of Zambia)*

Although few low-income and middle-income countries have powerful consumer movements, this example shows the unmet potential represented by mobilisation of service users to ensure that their concerns are heard by decisionmakers.

Fifth, the general public's interest in the wellbeing of those with mental disorders was reported to be low. L Vijaykumar, of the Indian non-governmental organisation, Sneha, noted the absence of a "ground swell of public opinion on mental health issues which will force the governments to allocate more funds for mental health". On the contrary, respondents argued that stigma—which is common in the general population and in the health sector[30–33]—is a barrier to progress.

Sixth, respondents suggested that advocacy might fail because decisionmakers often have the incorrect perception that mental health care is not cost effective relative to care of many other conditions.

> "In Afghanistan...the national health authorities defined mental health as a priority, but the donor community had huge hesitations to fund service delivery. The main reason stated for this reluctance of the donors was the unavailability of clear studies about the cost-effectiveness of public mental health interventions. The institution charged with 'costing' the Basic Package of Health Services...said they could not provide the government and donors with data on the estimated costs and benefits."
>
> *P Ventevogel (HealthNet-TPO)*

Perceptions of insufficient gains from investment in mental health are not only common among international donors but also among national-level decisionmakers, who might "come to the World Bank and express the need for funding for mental health, but are not willing to take a loan for these activities. Policymakers [...] believe that mental health care is a 'charity' issue. They do not believe that there will be a return on investment" (F Baingana).

Cost-effectiveness, for which data are increasingly available, varies for different mental disorders and problems.[34,35] For example, antiretroviral treatment for HIV/AIDS, which is firmly on the international public-health agenda, is as cost effective as treatment for depression delivered in primary care,[15,34] which has not been widely implemented. Decisionmakers usually do not have up-to-date knowledge about the cost-effectiveness of mental health care and, thus, they often direct funding toward less cost-effective care. Respondents to our survey noted that, in many countries, scarce mental health funds are spent on long-term institutional care at mental hospitals and on new, patented, pharmaceuticals which, in general, are much less cost effective than community-based care and generic essential medicines.[34,35]

Organisation of services

The way in which mental health services are organised affects treatment coverage for people with diverse mental disorders.[36,37] Respondents were asked how low-income and middle-income countries should invest their scarce resources for mental health care. Many respondents discussed decentralisation of tertiary-care institutions,

development of community-based rehabilitation services, psychiatric care in general hospitals, and mental health care in primary-health care and other health-care settings.

The centralised location of most mental health resources (staff, budgets, and beds) in or near large cities was described by respondents as a key barrier to progress. Respondents reaffirmed the long-standing public-health and public mental health recommendation that resources for care need to be geographically decentralised so that care is available and accessible in the community.[38]

Most respondents were critical of large psychiatric institutions; some argued that progress was hindered in countries with such institutions. The respondents' main arguments were that institutions tend to consume a large proportion of scarce mental health resources (budgets, beds, and staff); have higher costs than care in the community; isolate people from support systems in their families and communities; and are associated with undignified life conditions, human-rights violations, and stigma. Many respondents recommended that large institutions should be downsized, or even closed.

Barriers to decentralisation and deinstitutionalisation are sizeable: despite long-standing recommendations,[38–40] four of five psychiatry beds in low-income and middle-income countries are still in mental hospitals.[18] Challenges to downsizing mental hospitals tend to be intertwined with challenges to development of community mental health services. Developing such services requires access to mental health resources that are mostly allocated to large psychiatric institutions. Yet, to avoid homelessness and neglect, many long-stay patients can only leave hospitals when care and support have been made available in local communities. Typically, additional funding will be needed during the transition to community care.

The vested interests of mental health professionals and hospital workers might be one of the most pervasive barriers to decentralisation. Hospital directors might fear that deinstitutionalisation threatens their power base. Mental health workers might fear forced relocation to rural areas, and might ask their trade unions to protest against policies that favour community-based care. According to A Minoletti (Ministry of Health, Chile):

> "The main barrier for downsizing psychiatric hospitals is the high political cost that this entails, due to the pressure from the trade unions of hospital workers and organisations of mental health professionals (who should learn new skills for community care and may also lose some of their present privileges). In relation to the above, there are no professionals appropriately trained to be leaders of the process of downsizing psychiatric hospitals and face its technical challenges and social and political barriers."

D Puras (Vilnius University, Lithuania) describes his experience in Eastern Europe and Central Asia:

> "Over many decades the ineffective self-feeding system of centralised psychiatric institutions has developed sophisticated skills of survival and resistance…The system is controlled by a powerful lobby of administration of psychiatric institutions, which have good relations with the political and academic establishment. Ideologically, the system is supported by a still prevailing culture of paternalism and dependence, which is based on the presumption that mentally ill people are not capable to make independent decisions, so psychiatrists and other staff need to take care of them in a very paternalistic way… Even service users and family organisations are often on the side of the traditional system, because they do not know about alternatives or get financially dependent on organisations or institutions lobbying for institutional care and the biomedical paradigm."

Moreover, division within government systems can hinder decentralisation. Two respondents, reflecting on experiences in Pakistan and South Africa, stated that successes in reform of policy or legislation at the national level do not necessarily translate to improvements in services in provinces or districts. Authorities at these levels of government, who were responsible for implementation of national policy and legislation, continued to allocate insufficient resources to develop mental health services. Similarly, respondents noted that, in some countries, competition between the government branches responsible for hospital services and community health have hindered transferral of human and financial resources to community care. Respondents argued for international technical assistance, because decentralisation of resources is seen as technically complex, and countries might be able to learn a lot from others that have successfully implemented community care.

Broad agreement emerged among respondents that a mixed model of services that prominently included mental health in primary health care would best serve the millions of people with mental disorders. H Whiteford (formerly of the World Bank) described a systems approach, which was the most common viewpoint among respondents:

> "I would argue for both an upskilling of the primary health care workforce in mental health and the expansion of specialist community mental health services. There will never be sufficient community mental health services to treat all people with mental illness so there cannot be a sole emphasis on these services. However primary care services cannot adequately diagnose and treat patients with serious mental illness without the support of specialised services. I believe the mutual interaction and support each of these service components gives to the other produces an outcome which justifies the resource implications of expanding both."

Although some respondents described model examples of integration of mental health into primary health care,

many discussed the past failures of attempted integration with primary health-care systems[41] (see also panel 3 on Nigeria). They identified three key barriers. First, primary health-care systems in low-income and middle-income countries tend to be overburdened with multiple tasks and patient loads, and primary health-care workers do not always have the necessary time to provide proper care for people with mental disorders. Second, primary health-care workers do not receive sufficient supervision and support by specialised services for the effects of training to be sustainable. This observation is in line with the 1978 Declaration of Alma-Ata,[45] which promoted a primary-care model "sustained by integrated, functional and mutually supportive referral systems" as an integral part of the country's health system. This influential declaration does not seem to have been closely read by many of the mental health leaders, who have tried to develop mental health as a free-standing activity in primary health-care settings, since the most common strategy for organisation of mental health in primary health care has been short-term training of workers without meaningful follow-up or supervision and without cultivation of district-level specialised services to act as backup. Training primary health-care staff in mental health care without considering their workloads and supervision can cause help-seekers to be exposed to inappropriate treatment. Respondents working in Afghanistan and the occupied Palestinian territory expressed concern that the ease of prescribing medicines in primary health-care settings can lead to over-prescription when workers neither have the skills nor time to differentiate between normal distress and disorder, and cannot offer or organise psychosocial supports. Paradoxically, a third barrier raised by respondents was that in many low-income and middle-income countries essential psychotropic medicines are not continuously available through primary health care, which can hinder appropriate care for people whose disorders can be effectively treated with medication.

Human resources for mental health

One well-established barrier to scaling-up of mental health services is the inadequate number of people who are trained to provide care.[14,49] Respondents pointed out that in many countries poor working conditions and low status of the profession mean that few people enter the mental health professions. At the same time, higher salaries in private practice and overseas mean that scarce psychiatrists are encouraged to leave governmental employment. Moreover, mental health professionals—whether they are psychiatrists, nurses, or social workers—have few incentives to live in rural areas where most people in low-income and middle-income countries tend to live.

Respondents suggested that more flexibility and creativity was needed to diversify the workforce, as far as possible by building on existing formal and non-formal resources (panel 4). Some argued that family members are the prime resource for care, and several advocated support for, and even formalisation of, their caregiver role. Yet, professional institutions might resist such flexible solutions. For example, P Delgado (Ministry of Health, Brazil), discussed the decision to train general medical doctors to take on the role of psychiatrists in small municipal districts. He wrote:

> "This public health decision found great resistance in the medical establishment. As a result, it has been subject to continuous negotiations."

Respondents described the mental health training received by general health workers during their formal

Panel 3: Nigeria: An ill-fated attempt to integrate mental health into primary care

The high rate of mental health problems and the associated disability and burden in general health-care settings and in the community in Nigeria have been well-documented.[42,43] Recommendations by the WHO in the 1970s[44,45] provided the necessary impetus for policymakers in Nigeria to consider integration of mental health into primary care. A programme to do so was formulated as part of the National Mental Health Programme and Action Plan, which was formally published as a policy document in 1991.[46] By promulgation of this programme, mental health has become the ninth component of the nation's primary-care service. The programme envisages that mental health services be scaled-up so that essential treatment, including psychotropic medications, is available to those in need in the community. Services are to be delivered by trained primary health workers, with coordinated supervision provided by specialist mental health workers.

15 years later, the programme has not had the desired effect on provision of mental health service to Nigerians. The service reaches only a minority of those in need: estimates suggest that fewer than 20% of people with mental health problems receive any services.[47] Of those who do receive service, hardly any get adequate treatment, even though research shows that evidence-based interventions can be delivered at affordable costs in the country.[48] The programme's laudable goal—to reduce stigma of mental disorders in the community and improve the knowledge and attitude of primary-care workers about mental health—has not been a success.[30,33] Most primary-care settings still do not have the basic psychotropic medications that were included in the essential drug list.

Many reasons can be advanced for the failure of the programme. First, primary-care workers remain poorly trained and supervised in mental health issues. Crucially, the Nigerian programme does not articulate a structured and clear link between primary-care workers and specialist mental health professionals. No effort was made to first develop secondary mental health services to sustain mental health training or support for primary-care services. Inadequate support for the primary health workers trained in basic mental health care could have resulted in their isolation and poor morale. Second, mental health services, in general and primary or community mental health service, remain especially poorly funded. Also, 91% of the 2005 mental health budget is directed at mental hospitals. This lopsided interest is further exemplified by the recent development of new stand-alone mental hospitals in the country, with the result that more than 80% of psychiatric beds are now located in mental hospitals. Third, political will to improve mental health services might not have yet increased. For example, no serious effort has been made to appoint designated senior officials to oversee mental health issues at the Ministries of Health across the nation. This official neglect receives little civil-society attention. No non-governmental organisation is active in Nigeria with advocacy for mental health reforms or the rights of mentally ill persons as its goal. The experience in Nigeria shows that although the goal of integrating mental health services into the primary-care system sounds attractive, implementation might fall below expectations because of inadequate planning and implementation of policy objectives.

Panel 4: Expert opinions on mobilisation of non-formal resources

"In my view, the first principle to guide every development of services would be to build on what already exists. It looks as if up to now, extended families and neighbours are doing a lot. In that sense, support to families and communities should be the first move. Any plan should be implemented with the view of examining, in the first place, how the local communities can contribute to this plan. This means that the actions should not be so much oriented towards more services but towards more 'resources', including informal resources and formal services."

C Mercier (University of Montreal, Canada)

"Family members in community mental health care must be recognised as KEY resource to community mental health system. Therefore psychosocial education can be promoted to impart some skills/knowledge on how to manage the burden of mental illness and increase their effectiveness as care providers."

C S Katontoka (Mental Health Users Network of Zambia)

"I am a firm believer in expanding the category of mental health care givers. I am enthusiastic about the training of hairdressers, barbers and priests to recognise the simple mental health disturbances and refer them for further therapy if necessary."

G Alleyne (Pan American Health Organisation)

Panel 5: Barriers to effective mental health training

"Training has to take place where people go for services. Often, medical students and psychiatric residents are trained in mental hospitals. The same goes for nursing students...The content of their teaching is often non-relevant for the programs and services that are needed in low and middle income countries."

I Levav (formerly WHO Regional Office for the Americas)

"Theoretical training without continuous on the job supervision is a very poor investment. In and out short courses, even with excellent trainers and on vital topics tend to be a waste of time without some form of follow up."

L Jones (International Medical Corps)

"As for the training process I am becoming less and less enthusiastic for the workshops, especially with 'training of trainers' notions. Often a lot of money is spent on workshops and not much output comes and there is seldom any follow-up."

I Patkai (Christoffel-Blindenmission)

"Training is perceived as a quick fix...Our experience here is that the best form of training is in the form of ongoing, hands-on supervision, problem solving and managing the sometimes huge structural constraints that can turn the training into practice."

R Giacaman (Institute of Community and Public Health, occupied Palestinian territory)

education, or during subsequent training, as too often short, theoretical, and without sufficient follow-up. They said that even training programmes that do have a practical component rarely involve work in the community; that this kind of one-off training is unlikely to be effective; and that resources such as staff and means of transport will be needed to improve field-based supervision (panel 5).

Respondents argued that for mental health services to develop, the few existing mental health specialists (eg, psychiatrists, psychologists, mental health nurses, and social workers) in the governmental system would have to change their role from provision of clinical care to continuous training and supervision in the community. Respondents argued that the shortage of trainers and supervisors would continue if the role of specialists was not redefined, and that they should only take clinical responsibility for people who present with complex mental health problems. Accordingly, redefining the role of specialists is essential to reforming mental health services in low-income and middle-income countries, and will require specialists to be trained in adult-learning methods to train and supervise others.

Public mental health leadership

Respondents were concerned that many national mental health leaders have insufficient public-health skills, and that this might hinder rapid progress of service development. In the words of one respondent:

> "Leadership cannot be expected from clinicians turned-by default-into-administrators/planners. Their views, experience, and training are not compatible with population-oriented mental health action"
>
> *I Levav (formerly of the WHO Regional Office for the Americas)*

Mental health leaders in low-income and middle-income countries have responsibility for complex tasks such as development of policy, strengthening of services, and advise on population-level interventions to prevent mental health problems. In addition to general management and leadership skills, these tasks require a population-wide vision. Many respondents noted the absence of mental health leaders with experience or training in public health in many low-income and middle-income countries. Often, senior psychiatrists who are promoted to become national mental health leaders focus on clinical management of individuals, rather than on population-oriented actions. Although psychiatrists might resist the promotion of non-psychiatrists as leaders, several respondents recommended appointment of general public-health leaders in mental health leadership positions.

Respondents identified various reasons that leaders tend not to have public mental health skills. In many

countries, general public-health training and health-services delivery have never addressed mental health, which has been left to psychiatrists. Internationally, few universities offer courses in public mental health to train future mental health administrators, planners, and leaders. Only a few international training and exchange opportunities exist to strengthen public mental health skills for leaders. Moreover, mental health leaders often have many clinical and hospital-management duties, in addition to private practices (to boost their meagre governmental salaries); as a result, they do not have the time or incentives to develop their public mental health knowledge through self-study or courses.

Lessons learned

Many lessons can be drawn from our survey about barriers to mental health service reform. First, many of the barriers to progress in development of mental health services can be overcome by generation of sufficient political will to improve availability of and access to humane mental health care. The words "politics" and "political" were repeated 145 times in the answers of the 57 respondents in our survey, without being prompted by use in the survey questions. Political will, in this context, refers to the inclination, shaped by convictions or incentives, for policymakers to take action and to make or block change. Political will is likely to be directly affected by national and international factors, such as lobbying by professionals, consumers' groups, and other advocacy groups; expressions of public opinion; and donors' political priorities. Factors that affect political will can be divided into three categories: the national political environment, domestic advocacy, and transnational influence.[50] Agents at all three levels create incentives and norms that influence the behaviour of policymakers.[51] As we have seen, mental disorders are usually low on the public-health priority agenda of national and international agencies and donors. At the national level, political will in government ministries responsible for health and social welfare is necessary to counter the resistance of various groups with vested interests—whether trade unions, managers of government departments, or professional associations—who might object to reforms. Strong political support is needed to realise modest innovations, such as acceptance of unconventional solutions for diversification of the workforce; creation of mental health units in ministries of health; appointments (where necessary) of public-health experts in mental health leadership positions; collaboration with ministries of social welfare; engagement of all relevant stakeholders to ensure community-based housing and livelihood supports for people with severe mental disorders; and implementation of powerful legislation and policies that protect people with mental disorders from human-rights violations.

Second, advocacy for people with mental disorders needs to be substantially improved and expanded.

Barriers	Challenges to overcoming barriers
Insufficient funding for mental health services	Inconsistent and unclear advocacy Perception that mental health indicators are weak People with mental disorders are currently not a sufficiently powerful lobby Lack of general public interest in mental health Social stigma Incorrect belief that care is not cost effective
Mental health resources centralised in and near big cities and in large institutions	Historical reliance on mental hospitals Division of mental health responsibilities between government departments Differences between central and provincial government priorities Vested interests of mental health professionals and workers in continuity of large hospitals Political risk associated with trade union protests Need for transitional funding to shift to community-based services
Complexities of integrating mental health care effectively in primary-care services	Primary-care workers already overburdened Lack of supervision and specialist support after training Lack of continuous supply of psychotropics in primary care
Low numbers and limited types of health workers trained and supervised in mental health care	Poor working conditions in public mental health services Lack of incentives to work in rural areas Professional establishment opposes expanded role for non-specialists in mental health workforce Medical students and psychiatric residents trained only in mental hospitals Inadequate training of general health workforce Mental health specialists spend time providing care rather than training and supervising others Lack of infrastructure to enable community-based supervision
Mental health leaders often deficient in public-health skills and experience	Those who rise to leadership positions often only trained in clinical management Public-health training does not include mental health Resistance of psychiatrists to accept other as leaders. Lack of training courses in public mental health Leaders overburdened by clinical and management responsibilities and private practices

Table 2: **Barriers to improvement of services and challenges to overcoming them**

Advocacy for mental health services will be more likely to succeed if such advocacy is informed by much needed research on the factors that shape political will for improvement of mental health services among different types of policymakers. Moreover, advocacy has not been sufficiently clear, informative, consensus-based, or focused. This observation has implications for national-level mental health planning. Indeed, few countries have consensus-based national mental health plans that have been written in consultation with key stakeholders, including non-governmental organisations, representatives of clients and consumers, and sectors other than health. Yet, in our experience, and according to our surveyed experts, such plans are vital—not just because sound planning is invaluable to successful development, but also because consensus-based plans are forceful vehicles for advocacy. By functioning as a coherent proposal for services, a well-developed national plan for mental health, that has been developed in a participatory way by the government, and with the participation of all key stakeholders, can lead to progress. For example, national-level consensus on mental health services in Albania, Sri Lanka, and the occupied Palestine territory has ensured support from both within these countries and from international donors.[9,10,24] Such plans need to be developed over a short timespan in a

participatory manner to communicate to political decisionmakers and funding sources that mental health stakeholders can agree and act swiftly, and to create the necessary momentum for implementation.

Third, development of secondary care-level community mental health services should be prioritised. Although this review does not cover the detailed technical aspects of developing mental health services,[52] survey respondents offered observations. They argued that mental health care delivered via primary health care and non-formal community resources require supervision and specialist back-up support, and that downsizing mental hospitals requires availability of a range of services and supports in the community. From these observations we infer that specialist community mental health services should be developed first when creating a mental health system in a district or province, to support responsible downsizing of mental hospitals and to sustain mental health investment in primary health-care clinics, which is essential for proper population coverage. Nonetheless, investment in primary care or existing tertiary care (eg, improvement of conditions in mental hospitals) is vital, and opportunities to invest in such care should be taken. Yet, such investments will probably go furthest if they are preceded by, or are at least in tandem with, development of community mental health services.

The fourth and final lesson of our review is an old lesson: people responsible for service development need to be much more effective in the way they use formal and informal resources that are already available in the community. The need for deinstitutionalisation and decentralisation of resources was covered in detail in the 2001 *World Health Report*.[5] The suggestion by respondents in our survey that specialist staff should be used mainly as supervisors, rather than as clinicians, was also raised by the report of the Institute of Medicine.[4] Moreover, our review highlighted substantial unused opportunities to engage non-formal human resources. The scarcity of formally trained mental health professionals in many low-income and middle-income countries suggests that more action is needed to ensure that non-professional community members take part in mental health programming. Survey respondents repeatedly advocated not only training and supervision for general health workers but also involvement of people with mental disorders, their family members, and other non-formal resources in the community. This viewpoint is consistent with the use of participatory action methods, which are common practice in community development.[53,54] These approaches have been increasingly applied to develop community mental health care for people with severe mental disorders in a range of low-income and middle-income countries.[55–57] Moreover, networks of people with mental disorders—organised into movements such as the Pan African Network of Users and Survivors of Psychiatry—promise to play a substantial part in increasing the availability of humane care in low-income and middle-income countries. Non-formal community resources will need to be recognised and mobilised to ensure access to care for the millions of people who need it. Accordingly, researchers who implement the research agenda described in the call for action in this Series[26] will need to design innovative research that involves use of non-formal community resources.

Our findings are largely consistent with existing mental health policy recommendations (table 1). The major difficulty has not usually been policy but its implementation. Most notably we highlight misinterpretation of the Alma-Ata Health for All declaration[45] to mean that development of mental health in primary health care can be a free-standing activity. Our review sends a clear message to all stakeholders involved in implementation of the call for action:[26] scaling-up of evidence-based mental health interventions will depend on strengthening mental health components of many levels of the health system, together with renewed attention to politics, leadership, planning, advocacy, and participation.

Contributors

BS initiated and provided overall supervision of this review, including the formulation of its framework and research question. BS and MvO designed the expert survey. BS, MvO, and CU drafted the questionnaire. RB and DS were responsible for qualitative data analyses. RB drafted the background paper with inputs from all authors. JM and MvO drafted the Sri Lanka case study, and OG drafted the Nigeria case study. AC compared the three high-level reports. All authors have seen and approved the final version. The final article was written by MvO with input from all authors. The views expressed in this review are those of the authors, and do not necessarily represent the decisions, policies, or views of the institutions which they serve.

Survey respondents

Atalay Alem (Addis Ababa University, Addis Ababa, Ethiopia), George Alleyne (Pan American Health Organization (PAHO), Washington, USA); Florence Baingana (Makerere University, Kampala; formerly World Bank, Washington, DC and Ministry of Health, Kampala, Uganda); Gary Belkin (Millennium Villages Project, New York and New York University, New York, USA); Jafar Bolhari (Institute of Psychiatry, Teheran, Iran), Thom Bornemann (Carter Center, Atlanta, USA and formerly WHO, Geneva, Switzerland); John Bowis (European Parliament, Brussels, Belgium), Bhargavi Davar (Bapu Trust, Pune, India); Mike Davies (Christoffel-Blindenmission, Manila, Philippines); Paramesheva Deva (Mara University of Technology, Shah Alam, Malaysia and formerly WHO, Manila, Philippines); Joop de Jong (City of Amsterdam, Amsterdam, and formerly Transcultural Psychosocial Organisation (TPO) and HealthNet-TPO, Amsterdam, the Netherlands); Pedro G Delgado (Ministry of Health, Brasilia, Brazil), André Delorme (WHO Collaborating Centre for Research and Training in Mental Health, Montreal, Canada), Domingos Savio do Nascimento (formerly, Ministry of Health, Brasilia, Brazil); Melvyn Freeman (Human Sciences Research Council, Pretoria, South Africa; and formerly Ministry of Health, Pretoria, South Africa); Rita Giacaman (Institute of Community and Public Health, West Bank, occupied Palestinian territory); DS Goel (formerly Government of India, Delhi, India), Karen Hetherington (WHO Collaborating Centre for Research and Training in Mental Health, Montreal, Canada); Gaston Harnois (WHO Collaborating Centre for Research and Training in Mental Health, Montreal, Canada); Mohan Isaac (University of Western Australia, Perth, Australia); Rachel Jenkins (Institute of Psychiatry, London, UK; formerly UK Ministry of Health, London, UK), Lynne Jones (International Medical Corps, Los Angeles, USA); C. Sylvester Katontoka (Mental Health Users Network of Zambia, Lusaka, Zambia); Pirkko Lahti (formerly Finnish Association for Mental Health, Helsinki, Finland); Itzhak Levav

(Ministry of Health, Tel Aviv, Israel; formerly WHO/PAHO, Washington, USA); John Mahoney (WHO Sri Lanka, Colombo, Sri Lanka; formerly UK Ministry of Health, London, UK),Custodia Mandlhate (WHO, Windhoek, Namibia); Elizabeth Matare (Zimbabwe National Association for Mental Health, Harare, Zimbabwe and World Federation of Mental Health, Springfield, USA), Joe Mbatia (Ministry of Health, Dar es Salaam, Tanzania); Céline Mercier (University of Montreal, Montreal, Canada; formerly WHO Collaborating Centre for Research and Training in Mental Health, Montreal, Canada); Harry Minas (University of Melbourne, Melbourne, Australia); Alberto Minoletti (Ministry of Health, Santiago, Chile); Richard Mollica (Harvard University, Boston, USA); A Rahimi Movaghar (Ministry of Health, Teheran, Iran); Srinivasa Murthy (WHO Iraq, Amman, Jordan; Formerly WHO, Cairo, Egypt and WHO, Geneva, Switzerland; formerly National Institute of Mental Health and Neurosciences, Bangalore, India); Ravi Narayan (People's Health Movement and Society for Community Health Awareness, Research and Action, Bangalore, India); Istvan Patkai (Christoffel-Blindenmission, Manila, Philippines); Pau Perez-Sales (Community Action Group and Hospital La Paz, Madrid, Spain); Michel Perreault (WHO Collaborating Centre for Research and Training in Mental Health, Montreal); Michael Phillips (Beijing Suicide Research and Prevention Center, Beijng, China); Dainius Puras (Vilnius University, Vilnius, Lithuania); Emran M Razaghi (Ministry of Health, Teheran, Iran); Khalid Saeed (WHO Collaborating Centre for Mental Health, Rapalwindi, Pakistan; formerly WHO, Beirut, Lebanon; WHO, Islamabad, Pakistan and WHO, Cairo, Egypt), Peter Salama (UNICEF, New York, USA), Diyanath Samarasinghe (University of Colombo, Colombo, Sri Lanka), Norman Sartorius (University of Geneva, Geneva; formerly WHO, Geneva and World Psychiatry Organisation, Geneva, Switzerland); Naotaka Shinfuku (Seinan Gakuin University, Fukuoka, Japan; formerly WHO, Manila, Philippines); Daya Somasundaram (University of Jaffna, Jaffna, Sri Lanka); Barbara Stocking (Oxfam GB, Oxford, UK); Rangaswami Thara (Schizophrenia Research Foundation, Chennai, India); Francisco Torres-Gonzàlez, (University of Granada, Granada, Spain); Robert van Voren (Global Initiative on Psychiatry, Hilversum, the Netherlands); Peter Ventevogel (HealthNet-TPO, Bujumbura, Burundi; formerly HealthNet International, Jalabad, Afghanistan); Lakshmi Vijaykumar (Sneha, Chennai, India); Xiangdong Wang (WHO, Manila, Philippines); Mitchell Weiss (University of Basel, Basel, Switzerland); and Harvey Whiteford (University of Queensland, Brisbane, Australia; formerly World Bank, Washington, USA).

Conflict of interest statement

We declare that we have no conflict of interest.

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